

PROGRAM COMPLIANCE/SYSTEM OF CARE
ADVISORY TEAM (PSAT)
(Formerly Staff Work Advisory Team)

MEDICAID MANAGED CARE (MMC) REGULATIONS

(Updated 1-06)

INFORMING MATERIALS

Q1. Can counties use their own documents instead of the products developed by the informing materials contractor, as long as they meet the requirements, or, will counties be mandated to use the products that the contractor develops?

A1. Per DMH/MHP contract, Exhibit A – Attachment 1, Section V (Beneficiary Brochure and Provider Lists), MHPs must use the informing materials provided by DMH within 90 days of the date on which the MHP receives the informing materials prepared by DMH.

Q2. What level of provider detail will be included in the provider directories?

A2. 42 CFR Section 438.10(f)(6)(i) requires that MHPs provide all beneficiaries with the name, location, and telephone number(s) of, and non-English languages spoken by the current contract providers in the beneficiaries' service areas. If the MHP requires that beneficiaries go through the MHP to access contract providers, the provider list must include instructions for how beneficiaries can find out if providers are accepting new patients, this could be simply listing a phone number to use for this purpose. If the MHP allows beneficiary to go directly to contract providers, the provider list must identify providers that are not accepting new patients. The provider list must include information on the category or categories of services available as well as information on cultural and/or linguistic services available from each provider. At a minimum, services available from the provider must be categorized as psychiatric inpatient hospital services, targeted case management services, and/or all other specialty mental health services. MHPs may elect to include instructions explaining how appointments may be scheduled.

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PROGRAM INTEGRITY

Q3. Is a fraud hotline established as part of a compliance plan supposed to be available to the staff, public, or both?

A3. *It is important to clarify that the Medicaid Managed Care (MMC) regulations do not specifically require a fraud hotline. 42 CFR Sec. 438.608(b)(4) requires that there must be arrangements and procedures in place so that the compliance officer and the MHP employees have "effective lines of communication." There is flexibility as to how this is achieved. Making a fraud hotline available to MHP staff is one way to meet the intent of this regulation, but may not be the most effective way for all MHPs. MHPs are encouraged to work with their county counsel and risk management offices to determine the most appropriate way to meet this requirement. Please note that counties may establish higher standards than the state or federal requirements.*

The communication referenced in 42 CFR Sec. 438.608(b)(4) is directed toward the compliance officer and the MHP employees. Medicaid and Medicare fraud hotlines have already been available to the public for several years at both state and federal levels, therefore, if MHPs choose to satisfy the communication requirement by using hotlines, it is not necessary to make them available to the public. MHPs are responsible for oversight and monitoring of their contractors and have the option of making the hotlines (or alternative means of communication) available to their contractors.

DMH offered Program Compliance training for MHPs in October 2003 that provided information, tools, and references intended to assist MHPs in developing compliance plans. The training and materials were largely based on Federal Department of Health and Human Services (HHS) Office of Inspector General (OIG) guidelines that encourage (but do not require) the use of fraud hotlines. DMH recognizes that there may be significant implementation variation among counties.

Whether MHPs use fraud hotlines, or other communication systems to meet the requirement of 42 CFR Sec. 438.608(b)(4), they should ensure that the MHP employees, and contractors (if applicable) are well informed of the related policies and procedures.

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BENEFICIARY RIGHTS

Q4. The MHP Contract, Exhibit A, Attachment 3, Item No. 4 states that a beneficiary may "request and receive a copy of his or her medical records, and request that they be amended or corrected." Can MHPs override such a request if it is not in the best interest of the patient, clinically?

A4. This particular beneficiary right incorporates parts of the HIPAA privacy rule. The exact language of 42 CFR, 438.100(b)(2)(vi) states:

"If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, [the beneficiary has the right to] request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in CFR Secs. 164.524 and 164.526."

Since MHPs are subject to the HIPAA privacy rules, they must grant beneficiaries this right, unless one of the exceptions applies. This is not a brand new requirement; MHPs were already subject to this when the HIPAA privacy rule became effective in April 2003.

45 CFR Sec. 164.524 describes an individual's rights and exceptions to accessing their records. This section (164.524(a)(3)(i)) addresses situations in which accessing the information would not be in the best interest of the beneficiary. The full text of 45 CFR Sec. 164.524 can be accessed here: http://a257.g.akamaitech.net/7/257/2422/05dec20031700/edocket.access.gpo.gov/cfr_2003/octqtr/45cfr164.524.htm.

45 CFR Sec. 164.526 describes the amendment process for changing medical records, and the exceptions. The full text of 45 CFR Sec. 164.526 can be accessed here: http://a257.g.akamaitech.net/7/257/2422/05dec20031700/edocket.access.gpo.gov/cfr_2003/octqtr/45cfr164.526.htm.

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GRIEVANCES AND APPEALS

Q5. What is the definition of "grievance"? If there are no more "informal complaints," what qualifies as an issue that must follow the resolution process, and what does not? When does a verbal 'bad hair day' remark transition into a verbal grievance? How do we decide if little gripes have to follow a formal grievance process?

A5. Per Title 42, CFR, 438.400(b), "grievance" means an expression of dissatisfaction about any matter other than an "action." If a beneficiary decides to use the MHP process to file a grievance, i.e., telling the designated grievance staff person, filling out a form, etc. for a minor issue then the MHP needs to follow the grievance process. If the beneficiary makes a remark to a receptionist, clinician, etc., in passing, but does not want to pursue further action, then s/he is not required to do so. Or, if a beneficiary makes a comment directly to his/her clinician, or another MHP staff person, but just wants to "vent," that beneficiary does not have to file a grievance with the MHP. In this example, the clinician, or other MHP staff person, should take the opportunity to remind the beneficiary of the available problem resolution processes.

Q6. Within what timeframe must the MHP send an acknowledgement that a grievance has been received?

A6. Neither the MMC regulations nor the DMH/MHP contract specify a timeframe by which the MHP must send the beneficiary written acknowledgement of the receipt of the grievance. MHPs should determine reasonable timeframes by which written acknowledgement must occur and follow their established standards. Grievances must be resolved within 60 calendar days.

Q7. What constitutes a "reasonable opportunity" for a client to present evidence in person? Must we present the client with this option, or must we make efforts to accommodate this option only if requested? Does this apply only to the appeal process or to the entire grievance process?

A7. MHPs should develop guidelines for determining "reasonable opportunity" and follow their established guidelines. MHPs must inform beneficiaries of their option to present evidence in person. Title 42, CFR, 438.406(b)(2) requires that MHPs provide beneficiaries a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. In addition, Title 42, CFR, 438.10(g) requires MHPs to inform beneficiaries of the grievance and

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appeal procedures and timeframes as provided in Sections 438.400 through 438.424, which include the requirement specified in 438.406(b)(2). The MHP brochure will include this requirement. Title 42, CFR, 438.406(b)(2) applies to appeals and expedited appeals only; it does not apply to grievances.

Q8. What is the new timeline for resolving a grievance? When does the timeline start?

A8. Grievances must be resolved within 60 calendar days. Title 42, CFR, Section 438.408(b) allows a maximum of 90 days, but DMH retained a 60 calendar day maximum, which is consistent with the timeframe for the former (Title 9) grievance process, which allowed up to 60 calendar days. The timeline begin at the time the beneficiary files his/her oral or written grievance.

Q9. If the issue is medication-related, must the decision-maker be a RN or MD? If not, must a RN or MD be consulted, or can resolution be given as long as it remains within the scope of practice of a LPHA?

A9. If the issue is clinical in nature, such as a medication issue, the decision maker must be a health care professional with the appropriate clinical expertise in treating the beneficiary's condition, therefore, resolution can be given as long as it is within the scope of practice of a LPHA and the individual making the decision was not involved in any previous level of review or decision-making (Title 42, CFR, Section 438.406(a)(3)).

Q10. What circumstances would justify extensions to the resolution timeframes?

A10. The MHP may extend the timeframe for grievance and appeal resolution by up to 14 calendar days if the beneficiary requests the extension, or if the MHP shows that there is need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, it must give the beneficiary written notice of the reason for the delay unless the beneficiary requested the extension (Title 42, CFR, Section 438.408(c)).

Q11. If the MHP requests a written appeal from the client and the client never provides the written notification, does the appeal process continue to resolution?

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- A11. *An oral standard appeal must be followed with a written, signed appeal. MHPs are required to assist beneficiaries with the problem resolution upon the beneficiary's request; therefore MHPs should make every effort to assist the beneficiary with filing a written appeal. A beneficiary may also authorize another person to act on his/her behalf and a beneficiary's legal representative may act on his/her behalf to use the grievance and appeal processes. If the beneficiary refuses to follow an oral appeal with a written, signed appeal, the appeal does not go to resolution. In this case, MHPs should note in their logs, and/or in the beneficiary's case file, attempts to assist the beneficiary with filing a written appeal.*
- Q12. Previously, the 2nd level grievance process involved a QIC committee to determine resolution of the grievance. Does the second level appeal have to be reviewed by a committee, or can an individual review it? If an individual can review the appeal, must the person providing the second level review be higher on the organizational ladder (e.g., supervisor or Mental Health Director, etc.) than the first person who provided the initial resolution, or can the second level of review be completed by any clinically appropriate person not involved in the case but not necessarily holding more decision making authority within the organization?**
- A12. *Title 9, CCR, Section 1850.205(e)(2) required MHPs to provide two levels of review for grievances, but did not specifically differentiate between the two levels. The two-level review process is not longer required in the new grievance system. Per Title 42, CFR, Section 438.406(a)(3), the individuals making decisions on grievances and appeals must not have been involved in any previous level of review or decision-making; and, if deciding on any of the following, are health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition:*
- *An appeal of a denial that is based on lack of medical necessity;*
 - *A grievance regarding denial of expedited resolution on an appeal; or*
 - *A grievance or appeal that involves clinical issues.*
- Q13. If a client, for whatever reason, had an inadequate supply of medication to last until his/her next MD appointment, and risked psychiatric decompensation, would this constitute grounds for an expedited appeal? If so, how does the MHP resolve this if the agency has no MD available and the medications requested cannot be obtained by the psychiatric hospital on an outpatient basis?**

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- A13. *Regardless of appeal status, MHPs are required to provide needed services, in this case medication, on an urgent or emergency basis. For any appeal to occur (standard or expedited) an "action" must have taken place. It is not clear in the example above if an action has occurred. If an action took place in this situation, and the beneficiary was at risk for psychiatric decompensation that would seriously jeopardize his/her life or health or ability to attain, maintain, or regain maximum function then his/her appeal would constitute an expedited appeal. DMH does not have the authority to set specific criteria for what constitutes an expedited appeal.*
- Q14. Given that the grievance process deals with mental health issues, excluding actions, and appeals process only addresses "actions", it appears that if a client is dissatisfied with the MHP resolution, it would no longer go to a 2nd level grievance but directly to State Fair Hearing (SFH), is this correct? If so, could the person who handled the grievance be a witness in the SFH, or must they remain out of the process?**
- A14. *The two-level review process is no longer required in the new grievance system. The MMC regulations require an action to occur before a case can qualify for a SFH. By definition, a grievance is an expression of dissatisfaction about anything other than an action. A grievance could generate an action if resolution is not rendered within the required timeframes. In this situation, the beneficiary could request a SFH. All other grievances would not qualify for the SFH process. If a SFH took place, a person handling the grievance or appeal could be a witness at the SFH given that a different party will decide the SFH outcome.*
- Q15. An "appeal" is a client appeal when they do not agree with the first decision and that "appeal" is now considered a SFH. There is no longer a second appeal to QIC. Correct?**
- A15. *No. An appeal is a request for review of an "action"; it is not a fair hearing. An "action" occurs when the MHP does any of the following:*
- (1) Denies or modifies MHP payment authorization of a requested service, including the type or level of service;*
 - (2) Reduces, suspends, or terminates a previously authorized service;*
 - (3) Denies, in whole or in part, payment for a service prior to the delivery of the service or denies, in whole or in part, payment for a service post-service delivery but pre-payment based on a determination that the service was not medically necessary or otherwise not a service covered by this contract;*

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- (4) Fails to provide services in a timely manner, as determined by the Contractor or;
- (5) Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

The new grievance process no longer requires two levels of review.

Q16. How are "action" items treated differently than grievances?

A16. "Action" is defined in the previous answer. An appeal is a request for review of an "action." A grievance is an expression of dissatisfaction about any matter other than an "action." Grievances and appeals follow different processes. The different requirements for grievances and appeals are specified in Title 42, CFR, Part 438, Subpart F.

Q17. If applicable, does the provider get a resolution letter as well as the beneficiary?

A17. The written notice of the grievance or appeal resolution goes to the beneficiary. In addition, per 42 CFR Sec. 438.210(c), MHPs must notify the requesting provider of any decision by the MHP to deny a service authorization request, or limit the amount, duration, or scope of the requested service. The provider notification must contain the required notice of action elements, but it does not have to be in writing.

Q18. Standard appeals are acknowledged in writing but expedited appeals are acknowledged orally. Since an expedited appeal is more serious than a standard appeal and documentation is important, why is written notification not required for expedited appeals?

A18. All appeals require written notice of resolution. For expedited appeals, MHPs are required to initially notify the beneficiary orally and then in writing. In addition, initial receipt of all appeals must be acknowledged to the beneficiary in writing.